The State of Access to Food and Nutrition in Montana

Report of the:

Montana State Advisory Council on Food and Nutrition

November
1995

THE ISSUES: TODAY AND TOMORROW

Today's rapidly changing political environment provides a challenging opportunity for the state of Montana to assess food and nutrition priorities. It is also time for the Montana State Advisory Council on Food and Nutrition (the Council) to recommend **POLICY and ACTION** to impact the development and maintenance of quality food and nutrition programs that lead to healthy families and communities. The directive for providing quality food and nutrition programs is grounded in the 1989 Montana Access to Food and Nutrition Act which states:

> ***It is the policy of the state of Montana that all citizens should have access to food programs and nutrition services to prevent any needy citizen from experiencing hunger and poor nutrition, and their impact on physical and mental health.***

Montanans' access to food and nutrition services and the resulting overall nutrition status is directly linked to a variety of factors at the national, state and local levels. It is critical to identify these factors affecting food and nutrition services. Current events and trends impacting food and nutrition services in Montana include high housing costs in some areas, lower paying jobs, national and state welfare reform efforts, as well as lifestyles and eating habits that contribute to a myriad of chronic diseases. It is important to evaluate the impact of these trends and to proactively address the outcomes.

Based on the ever-changing political climate and Montana's policy noted above, the Council recommends the state of Montana address and evaluate the following issues as priorities.

❖ WELFARE REFORM

The Montana Department of Public Health and Human Services (MDPHHS) will implement significant changes in Montana's health and welfare programs starting in February 1996. In general, most Montanans are in agreement that welfare reform is necessary and could have positive outcomes for all Montanans. MDPHHS has put a great deal of time and effort into developing ***Families Achieving Independence in Montana*** (FAIM) which emphasizes self-sufficiency by moving people off public assistance programs. Discussion and review of FAIM have resulted in divergent responses about the potential impact of welfare reform on the nutritional status of at-risk Montanans. The Council recognizes the following issues as meriting ongoing discussion:

- ❖ FAIM will include an option for clients to participate in nutrition and budgeting classes. Such educational opportunities are critical for families with limited incomes. As housing and other expenses increase, families too often have less money to spend on adequate and nutritious food. All education opportunities should incorporate sound adult-education principles and meet the greatest needs of clients. Without this foundation, education efforts may have little or no impact.

- ❖ The Council supports strong formative and summative evaluation to ensure that changes with FAIM have a positive rather than negative impact on the nutritional well-being of at-risk Montanans. FAIM must be responsive to evaulation outcomes to ensure positive changes.

- ❖ Under FAIM, there will be a number of allowable activity requirements. These include, but are not limited to working a minimum number of hours or improving employability by pursing a post-secondary education. FAIM will provide for limited child care allowances for parents enrolled in post-secondary education. There may be shortages of affordable, quality child care. The

alternative will be for families to pay for more costly child care which can strain limited incomes and once again impact the amount of money available to buy food.

Factors outside of Montana, namely, block grants will also have an impact. Montana has yet to realize the impact of block grants on the state. Program eligibility and benefits, as well as total dollars available, will undoubtedly be affected.

It is appropriate to involve the Council and other groups, including the Montana Hunger Coalition, in decisions that relate to food and nutrition access in the context of both welfare reform and block grants. In addition, concerned citizens at the local level need to become involved in community planning efforts to ensure access to food and nutrition is not reduced.

Under the present scenario, the status of access to food and nutrition will be positive **ONLY** if significant and immediate changes occur to improve the employment picture. The diminishing availability of affordable, quality child care, health care and housing will impact the ability of Montana families to become self-sufficient in the next three to eight years. If such changes do not occur, the long-term impact could be an increased risk for poverty, hunger and poor nutritional status in Montana.

❖ UNDER-SERVED AND HIGH-RISK POPULATIONS

❖ American Indian People

There are many food and nutrition issues facing Montana's American Indian people. Two are addressed in this report: the prevalence of diabetes on and off the reservations, and access to quality affordable food on the reservations.

For American Indian people in Montana, two of the five leading causes of death are related to the way they eat. Diabetes mellitus and diseases of the heart account for 23.7 percent of all deaths for American Indian people. Diabetes alone accounted for 17 percent of direct outpatient visits in Montana's Indian Health Service facilities for FY 1993.

The American Diabetes Association estimates that for every person diagnosed with diabetes, there is another person who has not been diagnosed. There are about 2,500 American Indian people, over the age of 18, in Montana with diagnosed diabetes. Therefore, it is safe to say there are approximately 5,000 American Indian adults living with the disease. The prevalence rate of diabetes for Montana's 20,899 American Indian people over the age of 18 is 24 percent. Only about half of Montana's American Indian population lives on reservations where access to quality health care, and diabetes intervention and education is available. Those living in urban areas do not have the same access and are more likely to suffer the long-term debilitating consequences of diabetes.

Access to affordable, nutritious and fresh food varies on different reservations. In general, food is obtained from small local grocery stores with a limited variety of food and/or high prices. Shopping at larger, more affordable and better supplied stores requires traveling 35 to 130 miles. The Food Distribution Program on Indian Reservations (FDPIR) exists on all Montana reservations. Meat, fruit and vegetables provided through FDPIR are canned and, the same foods are provided month after month. Eligible individuals are able to participate in either the FDPIR or the Food Stamp program. Some people alternate between the programs.

Access to nutrition education and information is often limited to those receiving a referral to the IHS or tribal health care system. On all reservations, the Montana State University Extension Service is currently providing nutrition education through the Indian Reservation Nutrition Education (IRNE) Program. IRNE is designed to help individuals stretch their food dollar while providing nutritious food for the family. This takes on a greater significance with the access limitations, the lack of variety in the FDPIR food and Dr. Paul Miller's research that shows a significant reliance on FDPIR as a main source of food. Continued funding for IRNE is questionable in the future.

❖ Children

In the fall of 1995, Dr. Paul Miller of the University of Montana in Missoula published, ***Hunger in the Morning: A Study of Montana's Public School Third Graders and Their Teachers and Principals.*** The study reported that 51 percent of third graders experienced hunger after school started in the morning. Hunger is defined as a condition in which the level of nutrition necessary for good health is not being met becasue one lacks access to food. Hunger was experienced regardless of income level or type of household. Almost two-thirds (61 percent) of students did not have help from a grown-up with making breakfast. The adverse consequences of hunger on learning have been well documented. A hungry child cannot learn. Innovative school breakfast programs in all schools and active participation in them will significantly reduce the number of children feeling hungry.

❖ Adults at Risk for Chronic Disease

Diet and sedentary lifestyle are risk factors for five of the top ten leading causes of death in Montana. These include heart disease, cancer, stroke, diabetes and atherosclerosis. Excess weight, high blood pressure and high blood cholesterol are also contributing factors. Eating styles low in fruits, vegetables and complex carbohydrate, while high in fat are of greatest concern.

The Montana Behavioral Risk Factor Survey (BRFS) is a statewide, random telephone survey of 1,188 Montana residents age 18 and older. It is an ongoing surveillance of key risk factors associated with chronic diseases. Trends indicate that a growing number of Montanans are becoming overweight and sedentary. Results of interest from the 1994 BRFS show that 30.6 percent of Montana adults are overweight while, 55.2 percent describe their lifestyle as sedentary. In addition, 24.7 percent have been told by a health care provider that they have high blood pressure. Only 24.4 percent report eating the recommended five daily servings of fruits and vegetables. People with low fruit and vegetable consumption experience twice the risk for most types of cancer than do people consuming higher intakes. People who eat four or more servings of fruits and vegetables daily have half the cancer risk of people who eat one or fewer servings daily.

To counter this trend, the state of Montana needs to place a greater emphasis on the preventive role of public health nutrition, and incorporate the goals of the ***Dietary Guidelines for Americans***, the ***USDA Food Guide Pyramid*** and the ***Healthy People 2000*** nutrition objectives into **ALL** food and nutrition programs.

RECOMMENDATIONS FOR CHANGE: POLICY AND ACTION

POLICY:

On September 14, 1995, the Council hosted a forum to develop specific policy recommendations to ensure the nutritional health and well-being of all Montanans. The forum enabled more than 50 participants

from across the state to look at the issues in the context of potential block grants and the reorganization of the Montana Department of Public Health and Human Services (MDPHHS). The Council strongly recommends that the state of Montana immediately adopt the following policies for all food and nutrition programs:

- **ADMINISTRATION POLICIES**
  - *develop and maintain* science-based nutrition standards for all food and nutrition programs
  - *ensure* adequate funding to provide for optimal levels of food and nutrition services
  - *provide* nutrition education for all food assistance programs and for all public health programs in which nutrition education could have a significant impact, and *collaborate* with the Office of Public Instruction (OPI) to ensure nutrition education as a component of a comprehensive health education curriculum in Montana's schools
  - *incorporate* the goals of the *Dietary Guidelines for Americans*, the *USDA Food Guide Pyramid* and the *Healthy People 2000* nutrition objectives into all food and nutrition programs' plans and activities
  - *develop and maintain* a strong evaluation and research component to assess, on an ongoing basis, the nutritional status of individuals, high-risk populations and the community-at-large, as well as specific program impact
  - *promote* all food and nutrition programs as health-related rather than welfare-related programs, incorporating strong health promotion and disease prevention components

- **COORDINATION POLICIES**
  - *perform* uniform data collection and ongoing program evaluation
  - *create* the infrastructure for coordinated nutrition education messages and activities for all public health, and food and nutrition programs

- **CONSUMER DIRECTED POLICIES**
  - *respond* to consumer food and nutrition needs and *adjust* program function as appropriate
  - *provide* innovative public education and outreach efforts to reduce barriers and increase participation in food and nutrition programs
  - *employ* education and communications strategies best suited for the audience to create a greater demand for healthy eating

- **PARTNERSHIP POLICIES**
  - *support* community empowerment to allow for community-based services and programs
  - *create* an infrastructure for state and local governments, as well as the private sector, that calls for role clarification and shared fiscal and outcome accountability for food and nutrition programs and services

Critical to **ALL** food and nutrition programs within MDPHHS is the assurance of the core functions of public health nutrition. The policy recommendations put forth by the Council will guide MDPHHS in meeting its public health responsibilities.

It is the responsibility of public health nutrition to generate organized community efforts to promote nutritional health, prevent hunger, prevent nutrition-related conditions and diseases and to assure or provide medical nutrition therapy. Actual activities and services to address nutrition goals and objectives in a community are conducted in a variety of settings including public agencies, and private organizations, providers and individuals. The activities for the core functions of public health nutrition are as follows:

- **ASSESSMENT:** the regular and systematic collection, assembly, analysis and dissemination of food and nutrition information as it relates to the health of the community.

- **POLICY DEVELOPMENT:** the development of and advocacy for implementation of comprehensive public health nutrition policies promoting the use of the scientific knowledge base in decision-making.

- **ASSURANCE:** the assurances that services necessary to achieve agreed upon goals are provided and evaluated, either by encouraging actions by other entities or by providing services directly.

ACTION:

The Montana State Advisory Council on Food and Nutrition recommends the following **ACTIONS** for implementing the above policies to assure the core functions of public health nutrition while addressing the concerns noted in *The Issues: Today and Tomorrow* section of this report.

HEALTHY COMMUNITIES

Utilizing a non-governmental community mobilization approach can allow food and nutrition programs to be coordinated with other services. In addition, ownership in and the direction of programs at the local level strengthens the commitment for positive change increasing the likelihood of improved community well-being and quality of life. ***Healthy Communities***, a worldwide effort, sponsored by the National Civic League, is a growing movement in Montana. The Council supports the movement and strongly encourages state and local governments to do the same in the form of in-kind collaborative efforts.

MDPHHS REORGANIZATION

The Council recommends that any reorganization of MDPHHS consider the following points:

- **ALL** food and nutrition programs[1] must be considered public health programs before they are viewed as welfare programs because of the **IMPORTANT** role they play in preventing nutritional deficiencies and nutrition-related chronic diseases.

- Some food and nutrition programs, such as WIC, serve as a critical link to the health care system. Any reorganization that places WIC outside of the public health arena could seriously jeopardize the health and well-being of WIC clients. WIC and CACFP also provide nutrition education that has a positive impact on the health of participants.

- Programs, such as food stamps, FDPIR and TEFAP, that currently lack nutrition education components or that offer intermittent nutrition education could be greatly strengthened with the incorporation of strong public health nutrition principles.

In light of the above points, the Council recommends the following:

- *Incorporate* the recommended policies into any current planning for food and nutrition activities within MDPHHS, including those associated with FAIM.

1. Commodities, Food Distribution Program on Indian Reservations (FDPIR), The Emergency Food Assistance Program (TEFAP), School Meals Program in OPI, Special Supplemental Nutrition Program for Women, Infants and Children (WIC), Food Stamp Program, Child and Adult Care Food Program (CACFP), and Senior Nutrition Program.

- *Consolidate* administrative and other responsibilities among food and nutrition programs. Such an action would improve coordination of all existing programs including benefits, education and services. It would also position MDPHHS to better identify unmet needs and gaps in service.

- *Utilize* registered dietitians at the state level to provide leadership and consultation for critical food and nutrition areas without current nutrition consultation. These include food assistance programs and maternal and child health programs.

- *Charge* the Montana State Advisory Council on Food and Nutrition to collaborate with other stakeholders, including the Montana Hunger Coalition, to develop, implement, monitor, and evaluate the mission, goals, objectives and activities of a *State Nutrition Plan*.

FOOD ASSISTANCE PROGRAMS & FOOD BANK UTILIZATION: 1990 vs. TODAY

Tracking of participation in public food assistance programs and food banks serves as a barometer of need for at-risk populations. The figures presented in this report show that with the exception of FDPIR, participation in Montana's programs and food banks has increased since 1990. A linear projection, based on current data, shows that if Montana maintains the status quo, participation will continue to increase.

The decrease in participation in FDPIR reflects national trends; the cause of the decrease may reflect an increase in food stamp utilization. This is an area that needs further research. The Senior Nutrition Program shows an overall decrease in total number of participants, but a significant increase in the number of home-delivered meals. There is an overall increase in the number of meals per clients. Clients are getting older and having more meals at home than at congregate sites. Of additional concern is the significant increase in food bank utilization. People are turning to food banks either as a substitute for public assistance programs or when assistance benefits do not meet the family's needs.

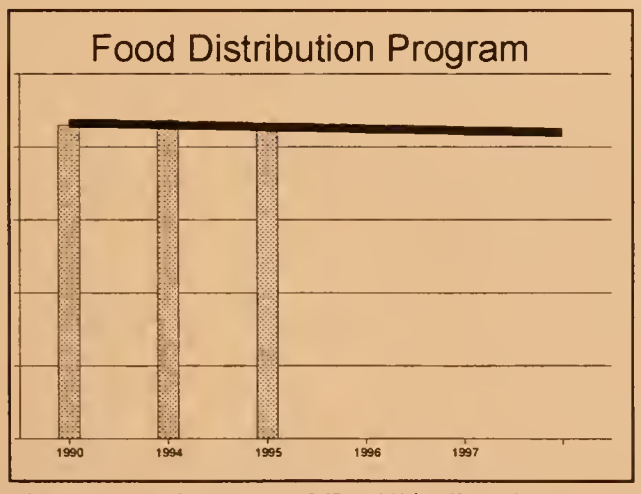

Figure 1: Dollar Value of Food Distributed

Dollar Value of Food Distributed

Total dollar value of food distributed based on a federal year of October 1 to September 30.

1990: $4,296,926

1994: $4,372,877

1995: $4,243,412

Contact: 444-4545; Gordon Davidson

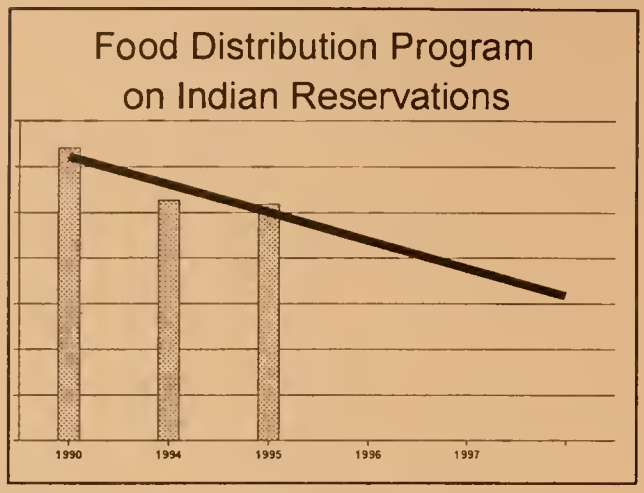

Figure 2: Average Number of Persons Served Monthly

❖ Average Number of Persons per Month

Average number of persons served per month based on a federal year of October 1 to September 30.

1990: 6,410

1994: 5,259

1995: 5,185

Contact: 444-4545; Gordon Davidson

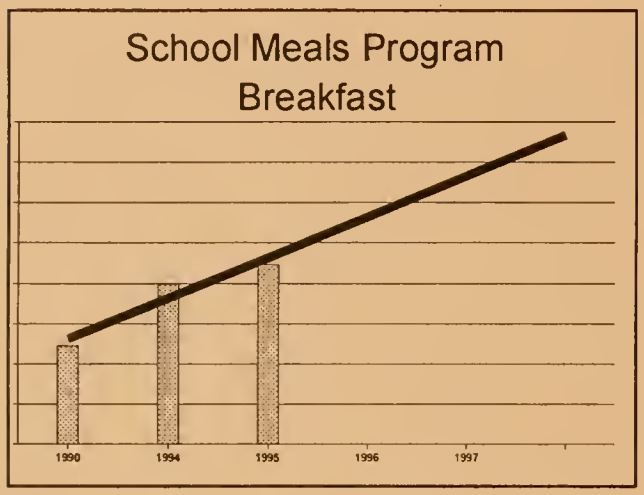

Figure 3: Student Breakfasts Served

❖ School Breakfast

Total number of breakfasts served based on a school year of September to May.

1990-91: 1,221,211

1993-94: 1,999,387

1994-95: 2,230,938

Contact: 444-2502; Ralph Kroon

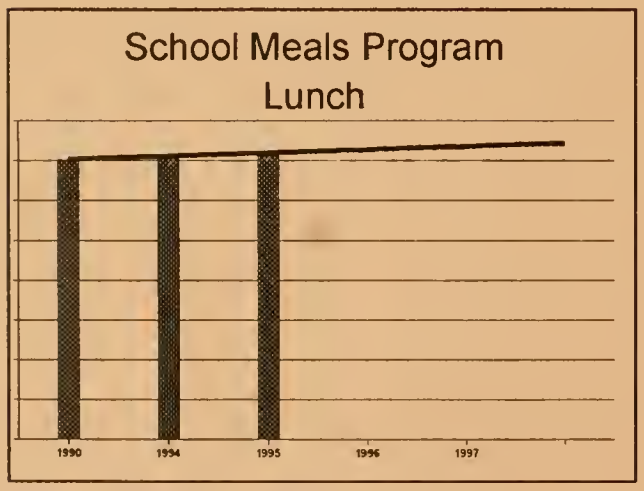

Figure 4: Student Lunches Served

❖ School Lunch

Total number of lunches served based on a school year of September to May.

1990-91: 14,035,930

1993-94: 14,308,038

1994-95: 16,596,251

Contact: 444-2502; Ralph Kroon

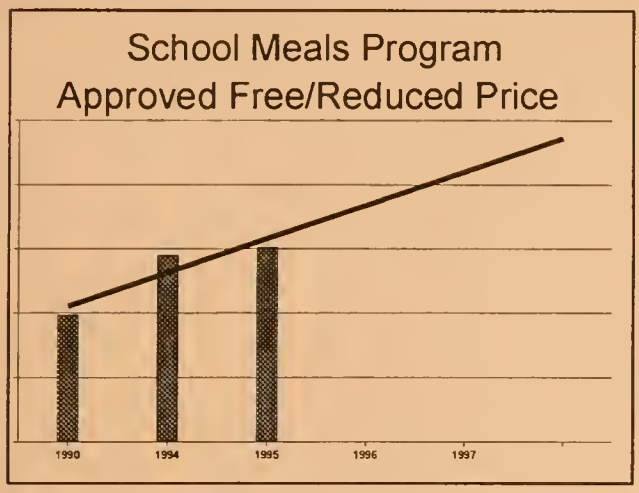

Figure 5: Total Student Free & Reduced Price Meals

❖ Free and Reduced Price Meals

Total number of free and reduced price meals served based on a school year of September to May.

1990-91: 39,747

1993-94: 57,849

1994-95: 60,418

Contact: 444-2502; Ralph Kroon

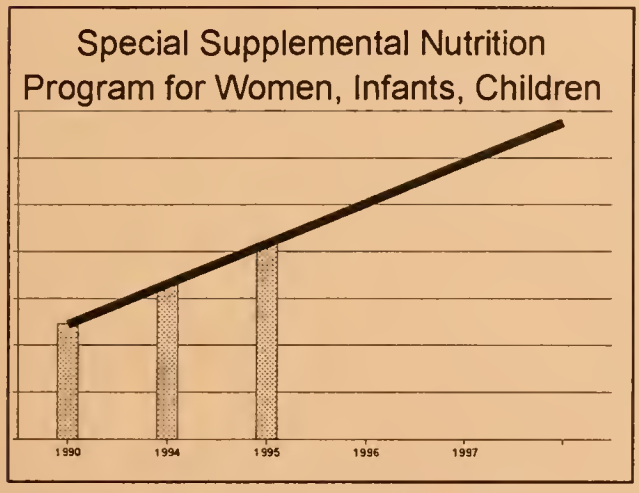

Figure 6: Average Number of Women Served Monthly

❖ WIC - Average Number of Women per Month

Average number of women served monthly based on a state year of July 1 to June 30.

1990: 2,460

1994: 3,288

1995: 4,183

Contact: 444-4747; Dave Thomas

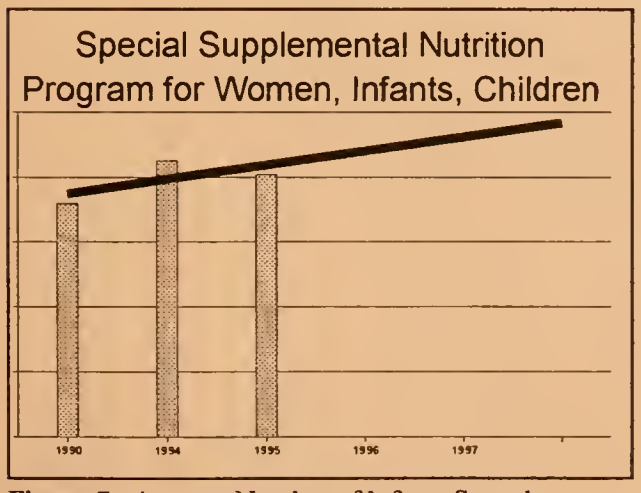

Figure 7: Average Number of Infants Served Monthly

❖ WIC - Average Number of Infants per Month

Average number of infants served monthly based on a state year of July 1 to June 30.

1990: 3,600
1994: 4,258
1995: 4,036

Contact: 444-4747; Dave Thomas

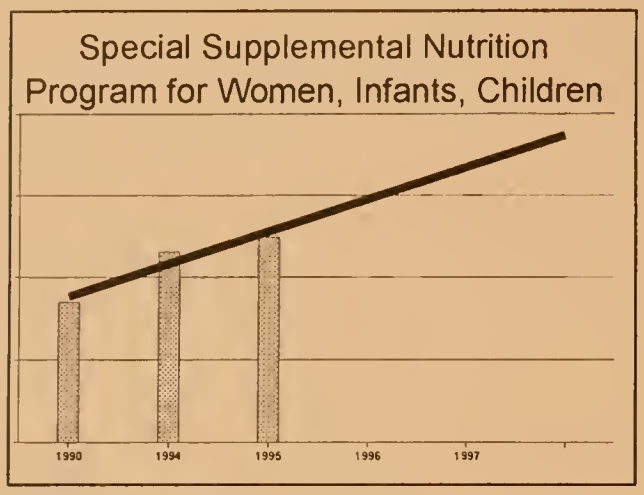

Figure 8: Average Number of Children Served Monthly

❖ WIC - Average Number of Children per Month

Average number of children served monthly based on a state year of July 1 to June 30.

1990: 8,490

1994: 11,531

1995: 12,440

Contact: 444-4747; Dave Thomas

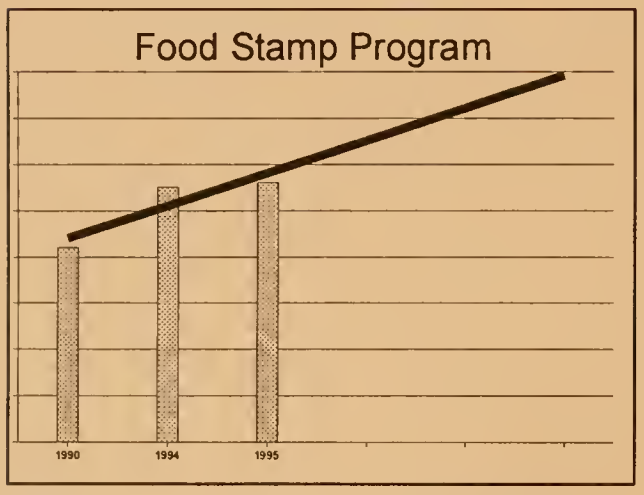

Figure 9: Average Number of Households/Month

❖ Average Number of Households per Month

Average number of households served per month based on a federal year of October 1 to September 30.

1990: 21,052

1994: 27,600

1995: 28,082

Contact: 444-4545; Bonnie McElroy

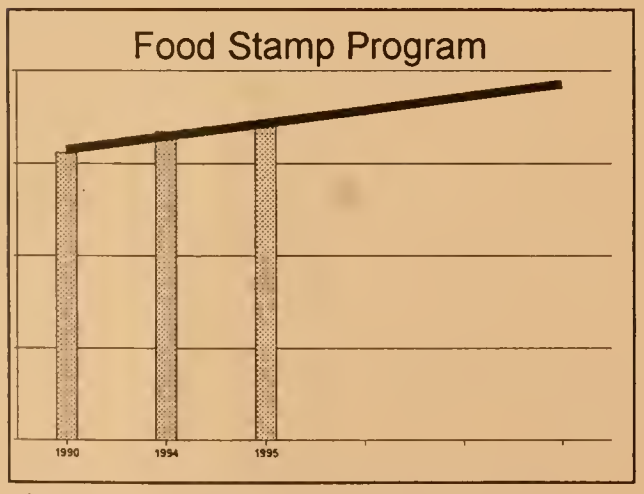

Figure 10: Average Dollars/Household/Month

❖ Average Dollars per Household per Month

Average dollars received per household per month based on a federal year of October 1 to September 30.

1990: $155.75

1994: $167.31

1995: $170.01

Contact: 444-4545; Bonnie McElroy

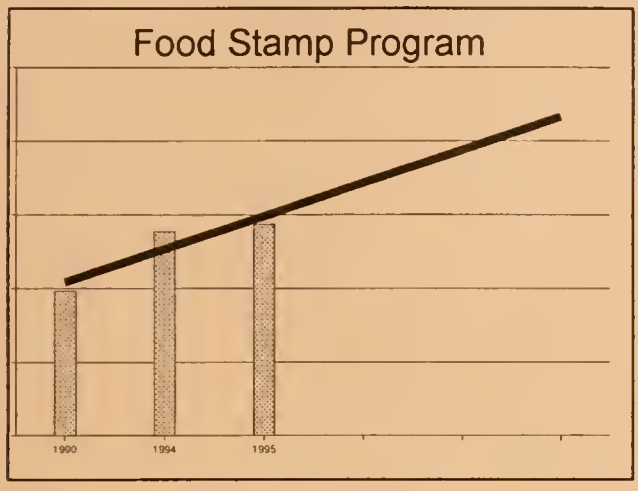

Figure 11: Total Dollar Value for Year

❖ Total Yearly Dollar Value

Total yearly dollar value of the Food Stamp program based on a federal year of October 1 to September 30.

1990: $39,347,072

1994: $55,413,520

1995: $57,290,523

Contact: 444-4545; Bonnie McElroy

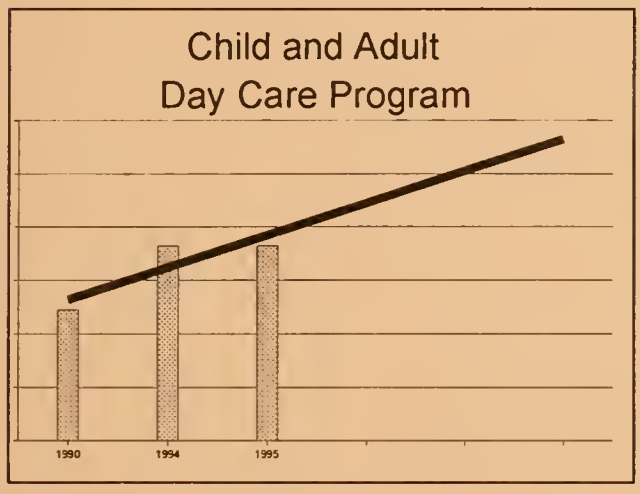

Figure 12: Total Meals Served

❖ Total Number of Meals

Total number of meals served yearly based on a state year of July 1 to June 30.

1990: 4,900,000

1994: 7,300,000

1995: 7,300,000

Contact: 444-2674; Tom Rippengale

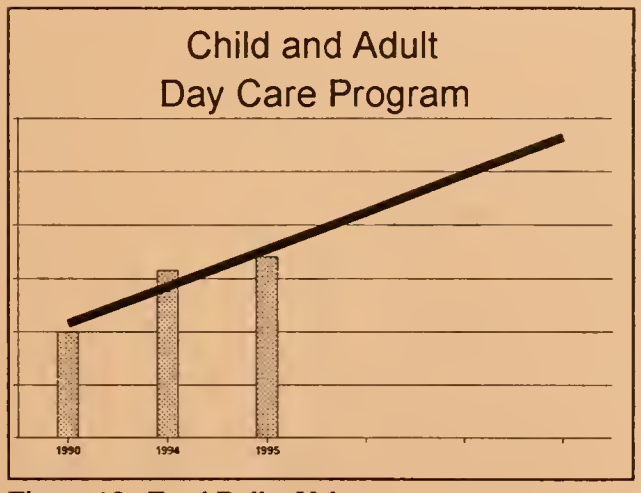

Figure 13: Total Dollar Value

❖ Total Yearly Dollar Value

Total yearly dollar value of meals served in the Child and Adult Care Food Program based on a state year of July 1 to June 30.

1990: $4,000,000

1994: $6,300,000

1995: $6,800,000

Contact: 444-2674; Tom Rippengale

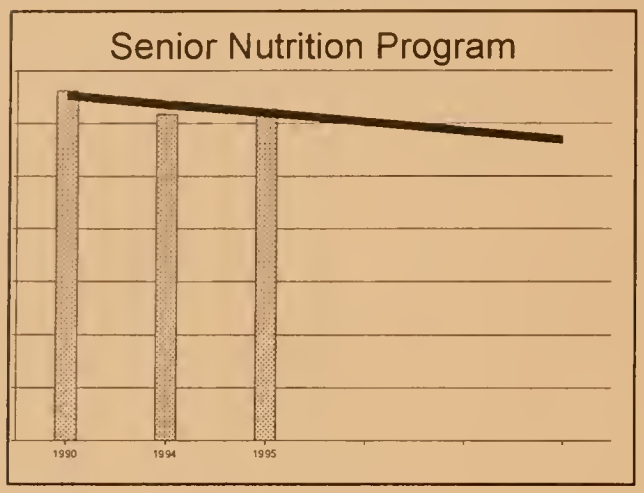

Figure 14: Congregate Meals Served

❖ Congregate Meals

Total number of congregate meals served based on a federal year of October 1 to September 30.

1990: 1,324,502

1994: 1,233,829

1995: 1,257,442

Contact: 444-7786; Janet Myren

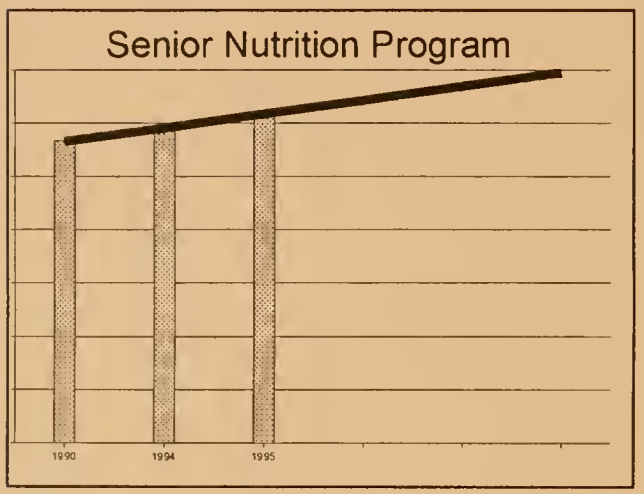

Figure 15: Home-Delivered Meals

❖ Home-Delivered Meals

Total number of home-delivered meals served based on a federal year of October 1 to September 30.

1990: 567,238

1994: 584,743

1995: 619,623

Contact: 444-7786; Janet Myren

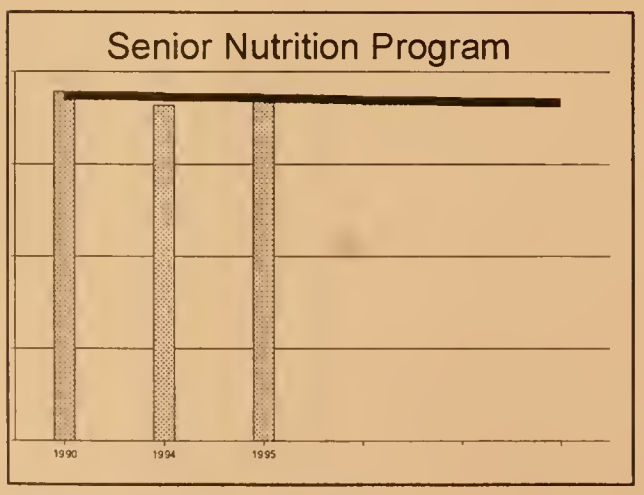

Figure 16: Total Meals Served

❖ Total Meals

Total number of all meals served based on a federal year of October 1 to September 30.

1990: 1,891,740

1994: 1,818,572

1995: 1,877,065

Contact: 444-7786; Janet Myren

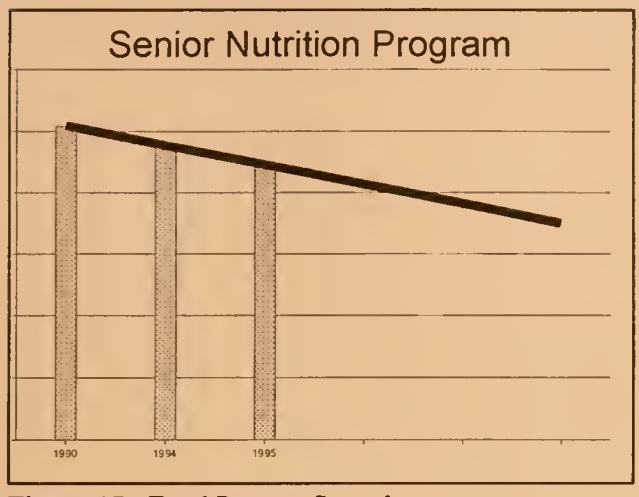

Figure 17: Total Persons Served

❖ Total Number of Persons

Total number of persons served based on a federal year of October 1 to September 30.

1990: 50,802

1994: 47,961

1995: 44,422

Contact: 444-7786; Janet Myren

Figure 18: Total number of clients served - not unduplicated numbers

❖ Total Number of Clients

Total number of clients served (not unduplicated numbers) through food banks participating in the Montana Food Bank Network based on a calendar year of January 1 to December 31.

1990: 127,377
1993: 177,177
1994: 236,158

Contact: 721-3825; Peggy Grimes

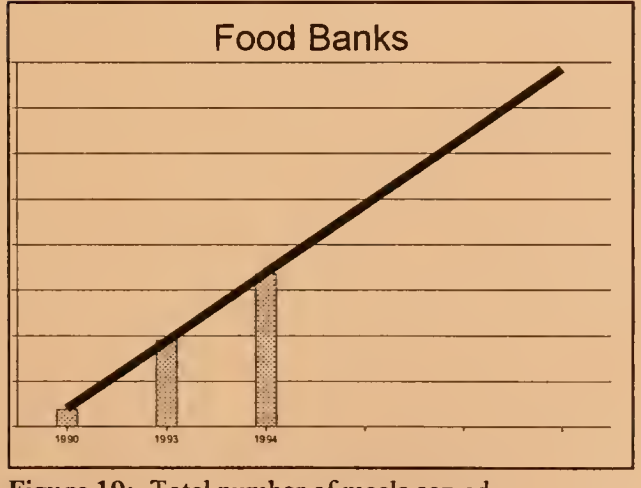

Figure 19: Total number of meals served

❖ Total Number of Meals

Total number of meals served through programs participating in the Montana Food Bank Network based on a calendar year of January 1 to December 31.

1990: 76,228
1993: 382,211
1994: 673,056

Contact: 721-3825; Peggy Grimes

PLAN OF WORK AND ACCOMPLISHMENTS: A REVIEW OF 1995

It is the mission of the Montana State Advisory Council on Food and Nutrition *to provide information and education to policy makers and the public on the state of access to food and nutrition in Montana*. The Council's 1995 Plan of Work reflected that mission. The following activities were accomplished.

❖ **PUBLIC FORUM ON FOOD AND NUTRITION POLICY:** The Council sponsored a public forum to develop policy recommendations, as well as market the Council's mission. More than 50 people working with food and nutrition issues, as well as those involved in the MDPHHS reorganization attended the forum. The agenda included an overview of the core functions of public health, brief presentations on existing food and nutrition programs within MDPHHS, and small group work. The small groups generated the policy recommendations found in the *Recommendations for Change: Policy and Action* section of this report. Nancy Chapman, MPH, RD, a nationally-recognized public policy expert from Washington, D.C. also participated in the meeting.

❖ **LOCAL COMMUNITY NUTRITION COALITIONS:** Council members have been working collaboratively with members of the Montana Hunger Coalition (MHC) to promote the development of Community Nutrition Coalitions (CNC). CNCs empower communities to solve local food and nutrition problems at the local level. An important step in the process is linking CNCs with appropriate state-level resources. Representatives of the CNCs have participated in a number of training sessions conducted by members of the Council and MHC.

❖ **FOOD AND NUTRITION STATUS REPORT:** Imperative to the process of solving local problems is identifying and prioritizing them through various assessment techniques. Again, the Council worked collaboratively with MHC to develop the *Food and Nutrition Status Report*, a survey tool to assess access to food and nutrition. The survey is currently being used in some communities. A long-term goal is to have the *Food and Nutrition Status Report* used statewide with the Council collating the results to provide a broader picture of the state of access to food and nutrition in Montana.

❖ **AWARDS:** The Council identified 16 groups and individuals who deserved recognition for their efforts to provide food and nutrition services to the citizens of Montana. Governor Marc Racicot presented recipients with their awards during a special ceremony at the Hunger and Homelessness Conference in Great Falls in October.

❖ **ANNUAL REPORT:** Each year, the Council prepares its annual report and submits it to the governor. With each subsequent year, the report is generating more media attention. This proves to be ideal opportunity for the Council to further its mission.

❖ **COLLABORATION:** In addition to the collaborative efforts already noted, the Council coordinated efforts with MHC and the Montana Foodbank Network for the annual Hunger and Homelessness Conference. Representatives of these three groups met to determine ways to better coordinate efforts.

MONTANA STATE ADVISORY COUNCIL ON FOOD AND NUTRITION: 1995 MEMBERS

- **CHRIS AHNER**
  Montana State House of Representatives Member
  Helena: 449-0055

- **WILLIAM CAREY**
  Montana Foodbank Network Member
  Missoula: 549-0543

- **SHARON ESTRADA**
  Montana State Senate Member
  Billings: 245-2828

- **RALPH KROON/GARY WATT**
  School Meals Program Member
  Helena: 444-2502

- **BONNIE MCELROY**
  Food Stamp Program Member
  Helena: 444-4545

- **MINKIE MEDORA**
  Montana Hunger Coalition Member
  Missoula: 728-4100

- **JANET MYREN**
  Senior Nutrition Program Member
  Helena: 444-7786

- **LYNN PAUL**, Chair
  Montana State University Extension Member
  Bozeman: 994-5696

- **DAVE THOMAS**
  Special Supplemental Nutrition Program for Women, Infants and Children Member
  Helena: 444-4747

- **CONNIE TOWNSEND**
  Consumer Member
  White Sulphur Springs: 547-3453

- **NONIE WOOLF**
  American Indian Member
  Browning: 338-6307

- **KATHY ANDERSEN**
  Staff to Council
  Helena: 444-2672

For additional information on the work of the Council, contact Kathy Andersen at (406) 444-2672 or any Council member.

700 copies of this public document were published at an estimated cost of $1.25 per copy, for a total cost of $875.00, which includes $490.00 for printing and $385.00 for distribution.

RECOMMENDATIONS FOR ACTION

Based on the information presented in the report, the Montana State Advisory Council on Food and Nutrition makes the following recommendations.

- *Incorporate* the recommended policies into any current planning for food and nutrition activities within MDPHHS, including those associated with FAIM.
- *Consolidate* administrative and other responsibilities among food and nutrition programs. Such an action would improve coordination of all existing programs including benefits, education and services. It would also position MDPHHS to better identify unmet needs and gaps in service.
- *Utilize* registered dietitians at the state level to provide leadership and consultation for critical food and nutrition areas without current nutrition consultation. These include food assistance programs and maternal and child health programs.
- *Charge* the Montana State Advisory Council on Food and Nutrition to collaborate with other stakeholders, including the Montana Hunger Coalition, to develop, implement, monitor, and evaluate the mission, goals, objectives and activities of a ***State Nutrition Plan***.

MONTANA STATE ADVISORY COUNCIL ON FOOD AND NUTRITION
C/O MDPHHS
ROOM C-317, COGSWELL BUILDING
1400 BROADWAY
HELENA, MT 59620

The Montana State Advisory Council on Food and Nutrition will lead and facilitate the creation of an optimal nutrition environment for all Montanans.